HOSPICE 101

PRESENTATION BY SURVEYORS

AUGUST 9, 2012

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And

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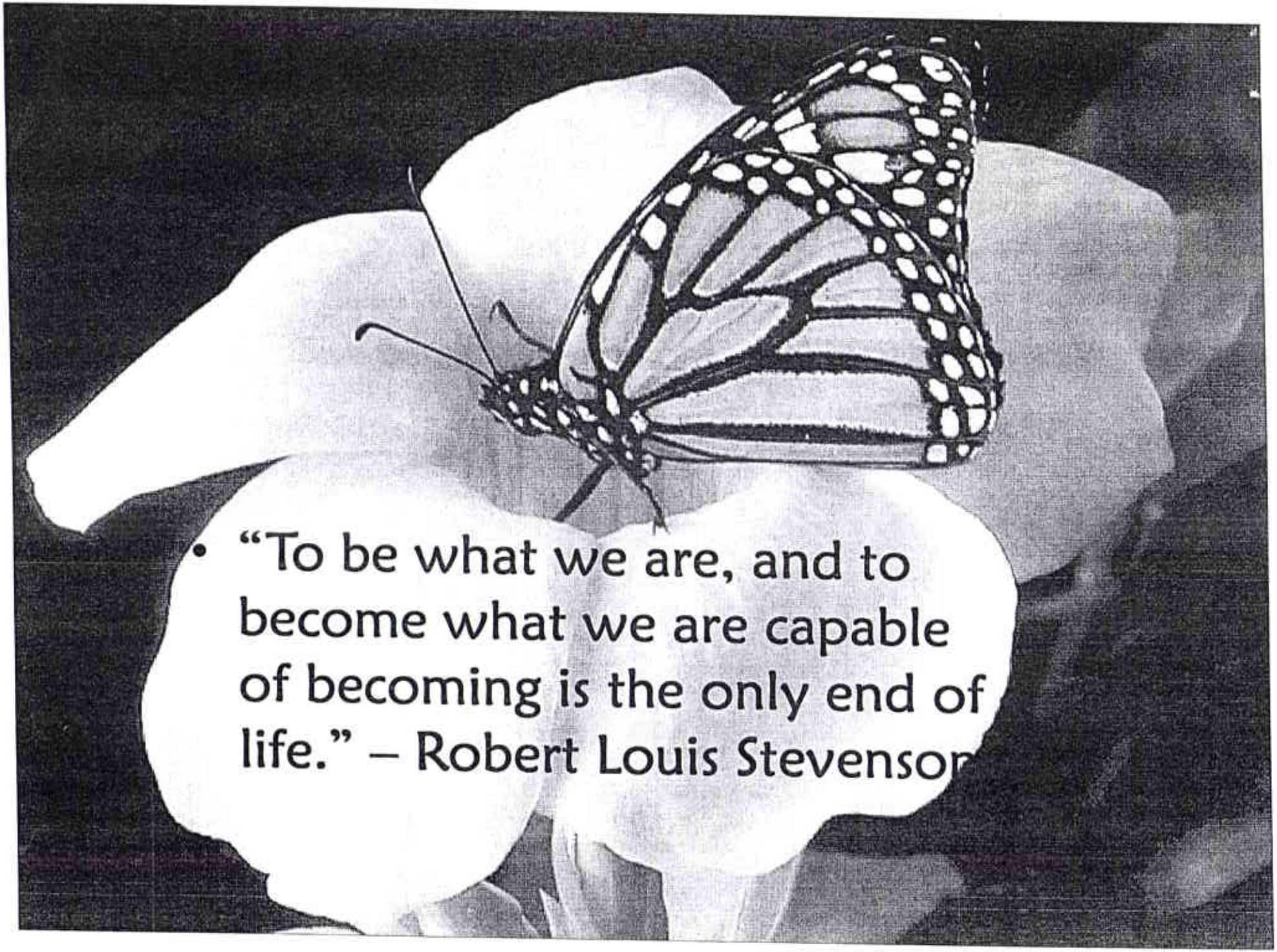
(State surveyors from Missouri Department of Health and Senior Services, the Bureau of Home Care and Rehabilitative Standards)


• "To be what we are, and to become what we are capable of becoming is the only end of life." – Robert Louis Stevenson

Initial Assessment (L522)

1) Done by RN within 48 hours after election of hospice care unless physician/patient or caregiver requests an assessment earlier than 48 hours.
2) Completed in the location hospice services will be delivered.
3) Includes important information that identifies the immediate needs of the patient/family including psychosocial, spiritual, physical and emotional needs.
4) Is not a "meet and greet" visit.
5) Must begin the plan of care.
6) The beginning of the comprehensive assessment that determines the involvement of other disciplines, including core and non core services.

Assessment Timeframes

(example)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 Effective Date of election	3 Day 1	4 Day 2 Initial assessment due	5 Day 3	6 Day 4	7 Day 5 CA completed

Per CMS Webinar

Comprehensive Assessment (L523)

1) Must be completed in 5 calendar days after the election.
2) Must include interdisciplinary group and the attending physician (if any).
3) The medical director must assume the role of the attending physician if the attending physician is unavailable.
4) L534 – must include data elements that allow for measurement of outcomes.
5) Hospices must measure and document data in the same way for all patients.
6) L535 – data elements must be used in individual patient care planning and coordination of services.
7) Must be used in the agency for quality assessment and performance improvement program.

Content of Comprehensive Assessment Must Include (L524)

1) Physical Needs
2) Psychosocial Needs
3) Emotional Needs
4) Spiritual Needs

Handout 3 Continued

Also the following factors must be included (L525-L533)

- L525-Nature and Condition Causing Admission
- L526-Complications and Risk Factors
- L527-Functional Status
- L528-Imminence of Death
- L529-Severity of Symptoms
- L530-Drug Profile that includes prescription & over the counter drugs, herbal remedies and other alternative therapies that affect drug therapy.
  a) Effectiveness of drug therapy
  b) Side effects
  c) Actual/potential drug interactions
  d) Duplicate Drug Therapy
  e) Drug Therapy with Laboratory Monitoring

- L531 – Bereavement
- L532 – Need for Referrals.

  Remember the initial/comprehensive assessment must include assessment of need for volunteers, homemaker and hospice aide services.
- L533 – Update of Comprehensive Assessment.
  a) Must be accomplished by the hospice interdisciplinary group in collaboration with attending physician, if any.
  b) No less frequently than every 15 days.

*Missouri Regulations states the group will meet no less often than every two weeks.

Content of Plan of Care

- L545-Patient/Family Goals.
- L546-Interventions to Manage Pain and Symptoms.
- L547-Scope and Frequency of Services Needed.
- L548-Measurable Outcomes.
- L549-Drugs and Treatments necessary to meet the needs of the patient.
- L550-Medical Supplies and Appliances.

- L551-Documentation of Patient's/Caregivers Involvement, Understanding and Agreement with the Plan of Care.

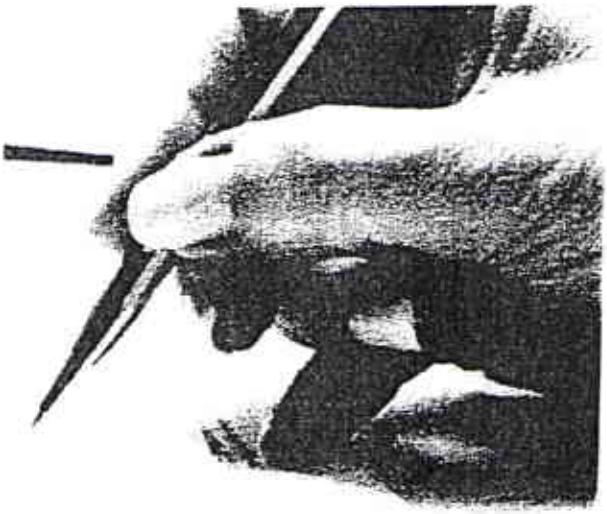
- L531-Initial Bereavement Assessment.

- L538-Must specify the care and services necessary to meet patient and family needs identified in all assessments.

- ML157-Physican's Orders

There must be documentation of a collaborative effort in establishing the Plan of Care involving all members of the IDG and the attending physician (if any).

COORDINATED TASK PLAN For Hospice Residents in Long-Term Care



Strategies & Tools to Improve the Coordination Process

COORDINATED TASK PLAN – INSTRUCTIONS

(back of form)

Policy

1. The Hospice agency will coordinate services with each LTC provider. The Hospice and LTC Provider will jointly ensure collaborative efforts between the LTC provider and the Hospice, by documenting which services will be provided, by whom, the frequency of services, updates when changes occur, dated signatures of both LTC provider and Hospice staff.

2. The Coordinated Task Plan will be initiated by the Hospice provider upon start of care in the LTC and will be continuously updated with any changes as needed.

3. At a minimum, the Coordinated Task Plan will be reviewed with recertification of the hospice resident.

Procedure

1. Complete the Hospice resident name, corresponding room number, and Hospice diagnosis at the top of the Coordinated Task Plan form.

2. Complete the name of the Hospice agency, phone numbers and staff assigned for each discipline.

3. Circle the days of the week the hospice nurse plans to visit. Update any on-going schedule changes on the next line.

4. Circle the days of the week the hospice aide plans to visit. Update any on-going schedule changes on the next line.

5. List the frequency of visits planned for the social worker, chaplain, volunteer or other staff. Update this section by marking through the previous schedule with one line and listing the new schedule with current the date.

6. For the wound care schedule, circle the days of the week that hospice will provide the wound care. Update any on-going schedule changes on the next line. The LTC provider will be responsible for wound care on all other days.

7. List frequency of foley catheter care under each party responsible.

8. List each treatment planned and document frequency under each party responsible.

9. Indicate by check mark or record the medical supplies provided ONLY by the hospice agency.

10. Indicate by check mark or record the DME provided ONLY by the hospice agency.

11. Document a start date for each new or changed intervention and an end date for each discontinued intervention.

12. Indicate at the bottom of the page, signatures and dates of both LTC representative and the Hospice staff member making the changes.

After multiple changes and updates, it may be necessary to initiate a new Coordinated Task Plan.

Hospice/LTC Coordinated Task Plan of Care

Resident Name:	Room #: Bed #:	Hospice Diagnosis:

Hospice Company:	
Daytime phone:	After hours phone:

RN Case Manager:	Hospice Social Worker:
Hospice Aide:	Hospice Volunteer:
Hospice Chaplain:	Other:

Date			Date		
Start	End	**Hospice Nurse Visits**	Start	End	**Hospice Aide Visits**
		Schedule S M T W TH F SA			Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Hospice Social Worker Frequency			
		Hospice Chaplain Frequency			
		Hospice Volunteer Frequency			
		Hospice Other Frequency			

Date		**Wound Care Schedule**
Start	End	**Hospice Wound Care**
		Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA

Date			Party Responsible & Frequency	
Start	End	**Treatments**	Hospice	LTC
		Foley Catheter Change		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medical Supplies Provided by Hospice:

[ ] Incontinence	[ ] Dressings	[ ] Foley catheter
Other	Other	Other
Other	Other	Other

DME Provided by Hospice:

[ ] Oxygen	[ ] Commode	Other
[ ] Bed	[ ] Nebulizer	Other
[ ] Walker	[ ] Wheelchair	Other

Hospice Staff Signature	Date	LTC Staff Signature	Date

Getting Started-Training Point Two

Examples of Implementing Coordinated Plans of Care through Resident Scenarios

SCENARIOS

The following are examples of how to correctly complete the Coordinated Task Plan of Care.

RESIDENT #1 *SCENARIO*

An 81-year-old female assisted living resident is admitted to hospice on December 14th with a diagnosis of CHF.

The hospice nurse will visit 2x/week, hospice aide 2x/week and the social worker and chaplain will both visit monthly and prn.

The resident has nebulizer treatments, which the LTC provider will provide and administer (Because the equipment is provided by LTC, it is not on the form). The resident also requires oxygen and a wheelchair, which hospice will provide.

There are no other treatments added and the intensity of visits is not required to change.

Please refer to next page for the completed Coordinated Task Plan of Care.

Hospice/LTC Coordinated Task Plan of Care
Resident #1 Scenario

Just For You Hospice Care

Resident Name: Rose Wood	Room #: 1234 Bed #: 1	Hospice Diagnosis: CHF

Hospice Company: Just For You Hospice CARE	
Daytime phone: (111) 222-3333	After hours phone: (111) 444-5555

RN Case Manager: GARY GARDENER	Hospice Social Worker: Susie SunFlower
Hospice Aide: Helen Hope	Hospice Volunteer: Violet Valley
Hospice Chaplain: Charlie Chaplin	Other:

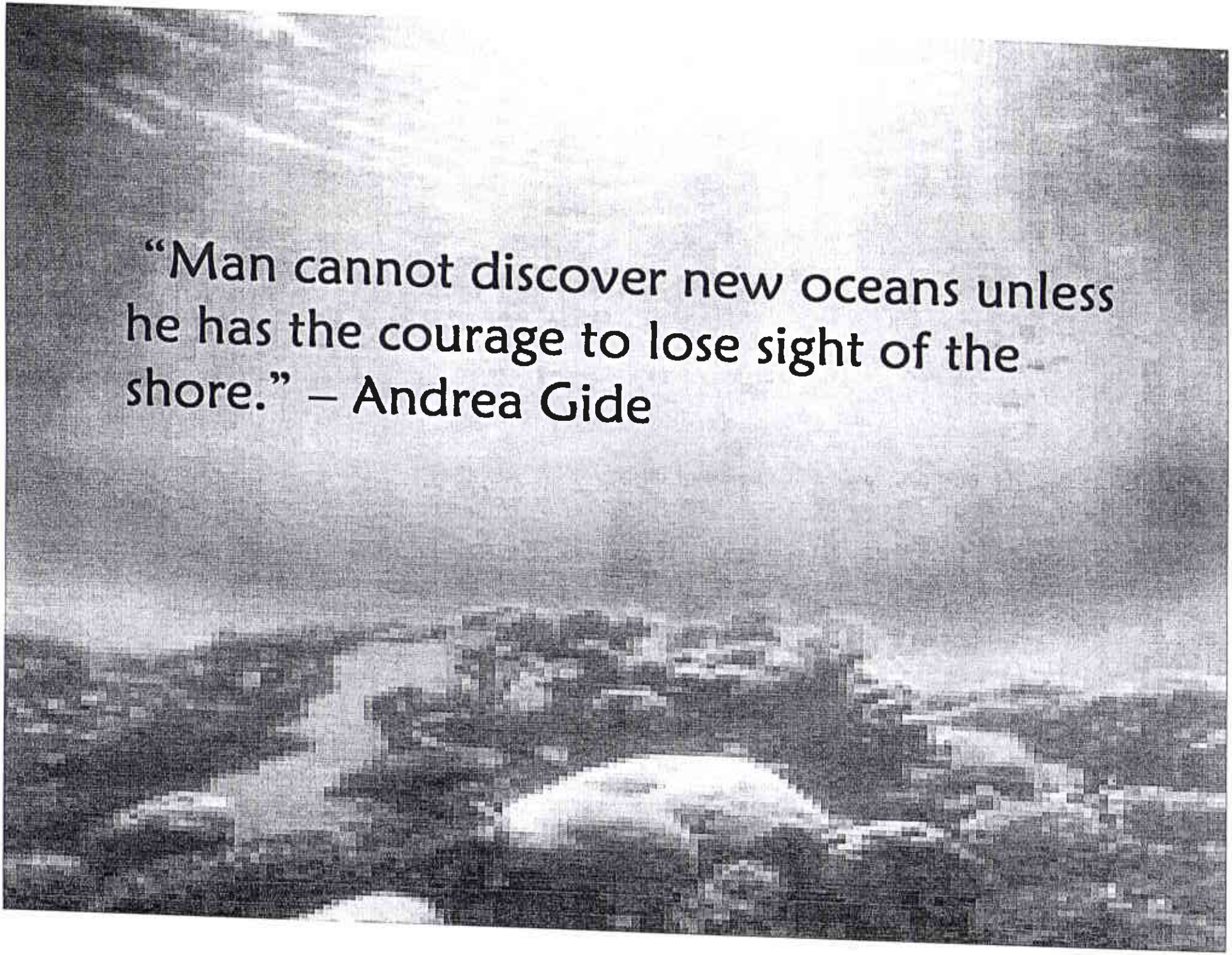
Date Start	Date End	Hospice Nurse Visits	Date Start	Date End	Hospice Aide Visits
12-14-09		Schedule S (M) T W (TH) F SA	12-14-09		Schedule S M (T) W TH (F) SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA			Schedule Change S M T W TH F SA
12-14-09		Hospice Social Worker Frequency Monthly			
12-14-09		Hospice Chaplain Frequency Monthly			
		Hospice Volunteer Frequency			
		Hospice Other Frequency			

Date Start	Date End	Wound Care Schedule
		Hospice Wound Care
		Schedule S M T W TH F SA
		Schedule Change S M T W TH F SA
		Schedule Change S M T W TH F SA

Date Start	Date End	Treatments	Party Responsible & Frequency: Hospice	Party Responsible & Frequency: LTC
		Foley Catheter Care		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medical Supplies Provided by Hospice:		
[ ] Incontinence	[ ] Dressings	[ ] Foley catheter
Other	Other	Other
Other	Other	Other
DME Provided by Hospice:		
[✓] Oxygen	[ ] Commode	Other
[ ] Bed	[ ] Nebulizer	Other
[ ] Walker	[✓] Wheelchair	Other

Hospice Staff Signature	Date	LTC Staff Signature	Date
D. Sandoger, RN	12-14-09	Penny Palmer, RN	12-14-09


"Man cannot discover new oceans unless he has the courage to lose sight of the shore." – Andrea Gide

WEBSITES

http://health.mo.gov/safety/homecare

To access the **"Bureau Talk"**, use the above website address. Click on "Publications". Then click on "Bureau Talk" and select year. After you are in that year's list of topics per quarterly publications, select the month of the issue you are seeking.

The following Bureau Talk issues contain significant information:

1) Hospice Medicare Interpretive Guidelines (federal regulations and guidance for Medicare's interpretation of each regulation). These can be found in the January 2009 Bureau Talk. (Attachment D)

2) The State Operations Manual (SOM, Chapter 2), which is the Medicare guidance and definitions of such processes as revocation, discharge, core services, etc) can be found in the October 2009 Bureau Talk (Attachment A).

3) The Missouri state regulations can be found in the October 2008 Bureau Talk (Attachment #5).

www.wocn.org

The Wound, Ostomy and Continence Nurse Association (WOCN)

www.npuap.org

The National Pressure Ulcer Advisory Panel (NPUAP)

Bureau of Home Care and Rehabilitative Standards office phone: 573-751-6336

Surveyors welcome calls from agencies regarding questions about hospice regulatory issues.

Top Ten Deficiencies

L0545 CONTENT OF PLAN OF CARE

L0798 FEDERAL, STATE, LOCAL LAWS & REGULATIONS

L0591 NURSING SERVICES

L0774 HOSPICE PLAN OF CARE

L0521 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT

L0684 DISCHARGE OR TRANSFER OF CARE

L0509 EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON

L0508 EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON

L0510 EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON

L0552 REVIEW OF THE PLAN OF CARE

The DO's Of DOCUMENTATION

FORMS:

- All hospice forms need to be signed and dated by the appropriate person(s).

ADVANCED DIRECTIVES:

- Document if the patient has an Advanced Directive. Request a copy for the clinical record and document each request made.

PAIN:

- Pain assessments should be conducted AT EACH VISIT with clear documentation of findings, interventions and any contact with physician.
- Document patient and family education and understanding regarding pain and symptom management.
- Document patient compliance based on appropriate monitoring and effectiveness of drug therapy.
- Document and monitor any new medications, changes in dosage and discontinued medication.
- Document teaching and understanding of any new medications, changes in dosage or discontinued medication.
- Document the effectiveness of any new medication, changes in dosage and discontinued medications during subsequent visits.
- Document a clear and concise description of patient pain.

MEDICATION:

- Document all medications (prescribed, OTC and herbal) on the patient's medication list.
- Document any changes in medication and update this change on the medication list and ongoing plan of care.
- Document that all medications were reviewed with the patient and the family.
- Document whether the patient/family are capable to administer medications. Document results of that capability.

- Document misuse (or suspected misuse) of a controlled substance and clearly document any contact with the physician or other appropriate person(s).
- Document the date, medication name, strength and quantity, signature of hospice staff and signature of person receiving a controlled substance medication when delivered to the patient's home.
- Document the patient/family received agency policies and procedures regarding the management of controlled drugs when applicable.
- Document any disposal of controlled substances. Documentation should include name of medication, strength and amount destroyed. Documentation should include signature of the hospice staff and signature of the witness.
- Documentation should clearly identify when a medication is found in the home and the documentation should include the name of the medication, dosage, frequency and route. Without this specific documentation we would expect to see a physician order.

SUPERVISION OF HOSPICE AIDE:

- Document supervision by the RN every 14 days (aide does not have to be present).
- Document supervision by the RN of an annual on-site visit with the aide.
- Documentation should clearly identify whether the aide is following the tasks, as assigned by the RN.

SUPERVISION OF THE LPN:

- Documentation by the RN must include a monthly, on-site visit to the patient for the purpose of evaluating whether the LPN is providing care as directed by the Plan of Care (LPN does not have to be present).

WOUNDS:

- Document wound measurements weekly. If more than one wound, documentation should be specific to each wound site.
- Document location, size, odor, drainage, appearance of wound(s) and surrounding skin.
- Document stage of wound(s).
- Document identification of the person(s) responsible for the day to day wound care.

- Document if patient/caregiver are compliant with providing wound care as ordered by the physician.
- Document specific treatment of each wound.

REVOCATION:

- Document the reason the patient chose revocation versus other options.
- Document the IDG was informed of revocation.
- Document a discharge summary was sent to the physician.

DISCHARGE:

- Document reason for discharge.
- Document discussion with the patient/family/IDG.
- Document a discharge summary was sent to the physician.

NURSING FACILITY:

- Document a single, coordinated plan of care in both the hospice and nursing home clinical record.
- Document updates taken to the facility.
- Documentation should identify the roles of each provider. (Example: who is providing the catheter changes, wound care, aide visits, etc.)
- Document not only the frequency but the exact days the hospice aide/facility aide will provide personal care.

ON-CALL:

- Documentation should include the exact date and time of:
  1. The original call.
  2. The response to the call.
  3. The follow up to the call.

***The above information is **only a small part** of the documentation requirements to determine compliance with the Conditions of Participation and to assure quality nursing care.

Remember…if it is not documented it is NOT done!!

DEFENSIVE DOCUMENTATION TIPS	
DO NOT	**DO**
➢ **Make generalized statements** "Patient states pain is better. Pain medication used."	➢ **Be specific and factual.** "Patient rated pain in left lower leg at 2 of 10 at present. Worst pain in last 24 hours was 6. Vicodin 5/325mg tablet used 2 times in past 24 hours with decrease in pain to 2. Patient is satisfied with pain control."
➢ **Avoid non-descriptive words such as stable, normal, within normal limits.** "Diabetic status is stable within normal limits"	➢ **Use objective patient-stated documentation to describe disease process and progress to goals.** "Patient reported checking blood sugar morning and evening. For past 5 days blood sugars in AM were 82-175. PM blood sugars were 100-200."
➢ **Do not document general statements for coordination.** PT documented: "Conferenced with SN."	➢ **Be specific. Document who you spoke with, care issues discussed, care plan problems, interventions and outcomes.** "Suzie RN notified of elevated blood pressure of 200/104 and pulse of 102. Patient stated saw doctor yesterday and medication changed. Norvasc increased from 5 mg daily to 10 mg daily. RN will notify physician."
➢ **Use standard goals and interventions on care plans and progress notes.** "Patient cardio-respiratory status will be within normal limits for patient." "Patient pain will be improved."	➢ **Individualize care plan per patient/ family issues, needs, goals and outcomes.** Use physician or agency established parameters for vital signs and blood sugars. Use patient stated goals for pain control. Relate goals to what the patient wants to be able to do when status improves.
➢ **Do not use judgmental language such as non-compliant, inadequate, dysfunctional, inappropriate** "Patient is non-compliant with his pain regimen."	➢ **Describe behaviors and events to paint a picture.** "Patient refuses to use Vicodin 5/325mg every 6 hours for pain rated at 4/10. Patient stated Vicodin caused upset stomach and dizziness."
➢ **Identify an issue, problem or concern and fail to address it in subsequent and ongoing contacts.**	➢ **Review previous visit notes. Address previously identified problems and document resolution.**

DO NOT	DO
➢ Use unknown abbreviations.	➢ Use only approved abbreviations which have been authorized by your organization.
➢ Use whiteout or writeovers.	➢ Follow agency policy for correcting documentation errors.
➢ Rely on memory.	➢ Document as close as possible to the time of service delivery.

QAPI Regulations

Condition of Participation	42 CFR 418.58
418.58(A)	Program Scope
418.58(B)	Program Data
418.58(C)	Program Activities
418.58(D)	Performance Improvement Projects
418.58(E)	Executive Responsibilities

Missouri Performance Improvement Regulation

ML266	(N) Performance Improvement. 1. The hospice shall follow a written plan for assessing and improving program operations which includes: A. Goals and objectives; B. The identity of the person responsible for the program; and C. A method for resolving identified problems.
ML267	2. The plan and performance improvement activities shall be reviewed at least annually by a designated group and the governing body and revised as appropriate.
ML268	3. When problems are identified in the provision of hospice services, the hospice shall document any evidence of corrective actions taken, including ongoing monitoring, revisions of policies and procedures, educational intervention, and changes in the provision of services.
ML269	4. The effectiveness of actions taken to improve services or correct identified problems shall be evaluated.
ML270	5. A designated group shall review and document the performance improvement activities and monitor corrective actions.

Handout 8 Continued

Hotline

- Effective May 1, 2010, the Home Health and Hospice Hotline number changed its operating hours from 24 hours a day to ~~8:00~~ 7:00 A.M. - 8:00 P.M.

- The Hotline is still available 7 days a week.

- After-hours callers will receive a message that asks them to call back from 8:00 A.M. to 8:00 P.M. They will not be able to leave a message.

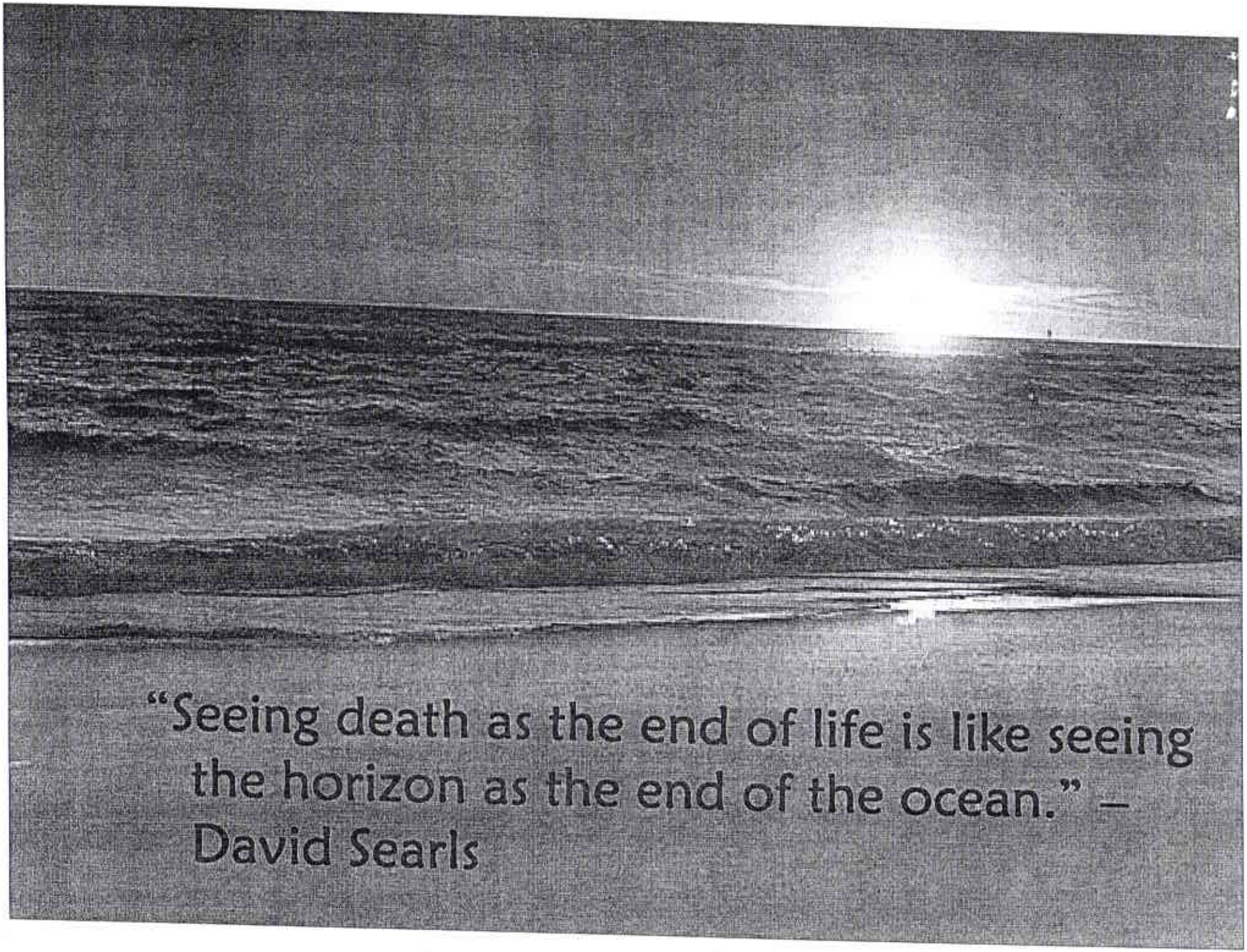
1-800-392-0210

One Hour Response Time

Per 19 CSR 30-35.010 (H) (1) & (3),

- "The hospice shall have written policies and procedures defining access to ***all services***, medications...during regular business hours, after hours and in emergency situations..."

- "When clinically indicated emergent visits shall be made within one hour from the time the need is identified."


"Seeing death as the end of life is like seeing the horizon as the end of the ocean." – David Searls

Hospice is a Medicare A covered service for those who qualify. Other payer sources could be Medicaid, private pay, insurance, VA or no pay.

A physician certifies the patient is considered to be terminally ill and has a medical prognosis that his/her life expectancy is 6 months or less if the illness runs it normal course.

Hospice is designed to meet the physical, psychosocial and spiritual needs of the patient/caregiver and all other needs related to the terminal illness.

There are state and Medicare regulations and both must be met.

Hospice consists of an interdisciplinary team that includes:

- Nursing
- Medical director and/or attending physician
- Social workers
- Counseling-spiritual/bereavement/dietary/other counseling
- Volunteers
- Hospice aides/Homemakers
- Therapies-physical therapy, occupational therapy, speech therapy

Hospice also covers all services and includes medications, respite, inpatient, medical supplies and durable medical equipment related to the terminal illness.

The patient does not have to be homebound.

Hospice is palliative care not curative treatment.

LEVELS OF CARE include:

- Routine home care-provided in a patient's home which could include nursing homes and assisted living homes
- Continuous care-hourly skilled care-must be at least eight hours during a twenty-four hour day, beginning at midnight and ending at midnight-

nursing care must be provided at least half of the period of continuous care-ONLY provided during periods of CRISIS

- Respite-provided for the relief of the caregiver—maximum of 5 days at a time
- Inpatient acute-provided in a Medicare certified facility-each shift must have a registered nurse who provides direct patient care-provided when pain and symptoms cannot be controlled-hospice must have a contract with the facility.

Hospice aides/homemakers are supervised every 14 days by a registered nurse and there must be documentation of the supervision.

Licensed practical nurses are supervised every month by a registered nurse and there must be documentation of the supervision.

Each patient must have a complete medication profile or drug list which includes a review of the following:

- Prescription medications
- Over the counter medications
- Herbal medications
- Other alternative treatments that could affect drug therapy.

The review must include:

- Effectiveness of the drug therapy
- Drug side effects
- Actual or potential drug interactions
- Duplicate drug therapy

- Drug therapy currently associated with laboratory monitoring (Coumadin, Digoxin)

Delivery of controlled substances to a patient's home must include:

- Date
- Patient name
- Medication name
- Strength of the medication
- Quantity indicated on the prescription container
- Signature of the hospice staff
- Signature of the receiver

There must be documentation in the clinical record that the patient/family has received the agency's policy and procedures for the management of controlled substances. There must be documentation of the delivery of controlled substances.

REVOCATION is a Medicare regulation. It is the decision of the family not the hospice agency. Revocation cannot be coerced in any manner by the hospice. If the patient/family chooses to revoke then the hospice must send to the attending physician a copy of the discharge summary and if requested a copy of the clinical record. The revocation form must be signed by the patient/representative and dated. Documentation must show the reason the patient chose to revoke and that the interdisciplinary team was informed.

TRANSFER

If the patient transfers to another hospice the transfer summary must include:

- Current medication list
- Advance directives (if applicable)
- Problems that require intervention or follow-up
- Discharge summary
- Copy of clinical record if requested

The transfer form must be signed by the patient/representative with the transfer date, the transferring hospice name and the receiving hospice name.

DISCHARGE

If the patient is discharged from the agency, other than death, the hospice must document team involvement, have an order for discharge, and consultation with the attending physician and medical director. The reason for the discharge, discussion and notification to the patient/family and date must be documented in the clinical record. The discharge summary must be sent to the attending physician.

DISCHARGE SUMMARY must include:

- Summary of the patient's stay including treatment, symptoms and pain management
- Current plan of care
- Latest physician orders
- Any other documentation that will assist in post-discharge continuity of care
- Any other documentation requested by the attending physician or receiving facility.

NURSING HOME

A patient may receive hospice services in a nursing home. There must be a single, coordinated plan of care in the hospice and nursing home. The interdisciplinary team is responsible for the overall coordination and communication with the nursing home. The patient that resides in a nursing home receives the same services that would be provided in the home.

The hospice must provide the nursing home with the following:

- Current hospice plan of care
- Hospice election form
- Advance directives
- Physician certification and recertification
- Contact information for hospice personnel/24 hour on-call system
- Current medication list
- Any hospice physician and attending physician orders that are specific to each patient.

Documentation updates to the plan of care must be in each clinical record. Documentation should identify the roles of each provider. Document not only frequency of the disciplines but the exact days the disciplines will visit (ex. Home health aide will give bath, nurse will change catheter, nurse will do wound care, etc.)

ON-CALL system—Missouri regulation

- Non-emergent call has a three hour response time
- Emergent call has a one hour response time.

Documentation should include the exact date and time for:

- The original call
- The response to the call
- The follow-up to the call.